

**STATE OF CONNECTICUT
DEPARTMENT OF PUBLIC HEALTH**Email: dph.nursingteam@ct.govWeb Site: www.ct.gov/dph/license**APRN – Notification of Intent to Practice Independantly**

Instructions to Licensee:

Please complete this form, scan it and email it to: dph.nursingteam@ct.gov. Please put “APRN Independent Practice” in the subject line. If you are unable to email it, please fax it to (860) 707-1981. Mailed forms will not be accepted or processed.

CT APRN License Number:	Last Name	First Name	Email Address
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I certify that, pursuant to the provisions of Public Act 14-12, I intend to practice as an Advanced Practice Registered Nurse independently and that I will maintain documentation of having engaged in the performance of advanced practice level nursing activities in collaboration with a Connecticut licensed physician for a period of not less than three (3) years and for not less than two thousand (2,000) hours. I further certify that such collaborative practice was completed in Connecticut.

I will maintain documentation of such practice for a period of not less than three (3) years after completing the requirements and will submit such documentation to the Department of Public Health for inspection not later than forty-five (45) days **after a request is made by the Department for such documentation.**

By completing this form I am providing written notice to the Department of my intention to practice independently and have in my possession the documentation described above. Documentation may include a dated letter from the Connecticut physician(s) that I collaborated with for a period of not less than three (3) years and for not less than 2,000 hours.

I also acknowledge that as a condition of license renewal I am required to maintain a current Connecticut registered nurse license, maintain certification by an approved certifying body and that I must complete a minimum of fifty (50) contact hours of continuing education within the twenty-four month period.

APRN Signature

Date